PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, January 25, 2000 at 10:00 a.m., Massachusetts Department of Public Health, Public Health Council Room, Second Floor, 250 Washington Street, Boston, Massachusetts. Present were: Chairman Howard Koh, M.D., Dr. Clifford Askinazi, Mr. Benjamin Rubin, Mr. Albert Sherman, Ms. Janet Slemenda and Dr. Thomas Sterne; Ms. Shane Masaschi, Mr. Manthala George and Mr. Joseph Sneider absent. Also in attendance was Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with the Massachusetts General Laws, Chapter 30A, Section 11A 1/2.

The following members appeared before Council to discuss and advise on matters pertaining to their particular interests: Dr. Bruce Cohen, Director, Research and Epidemiology, Ms. Abbie Averbach, and Ms. Jennifer Norton, Division of Health Statistics, Research and Epidemiology; Ms. Nancy Ridley, Assistant Commissioner, Division of Health Quality Management, Dr. Paul Dreyer, Director, Division of Health Care Quality; Mr. Howard Wensley, Director, Division of Community Sanitation; and Attorney Tracy Miller, Deputy General Counsel, Office of the General Counsel.

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RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF SEPTEMBER 28, 1999:

Records of the Public Health Council meeting of September 28, 1999 was presented to the Council. After consideration, upon motion made and duly seconded, it was voted (unanimously): That, records of the Public Health Council Meeting of September 28, 1999, copies of which had been sent to the Council Members for their prior consideration, be approved, in accordance with Massachusetts General Laws, Chapter 30A, Section 11A 1/2.

PERSONNEL ACTIONS: No Discussion

In a letter dated January 14, 2000, Dr. Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Janice Mirabassi to Program Manager VI (Director, Women's Health Unit). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Janice Mirabassi to Program Manager VI (Director, Women's Health Unit) be approved.

In a letter dated January 14, 2000, Dr. Howard K. Koh, Commissioner, Department of Public Health, recommended approval of the appointment of William Howley to Fiscal Officer V (Director of Financial Services). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of William Howley to Fiscal Officer V (Director of Financial Services) be approved.

In a letter dated January 14, 2000, Dr. Howard K. Koh, Commissioner, Department of Public Health, recommended approval of Sara Miranda to Program Manager VI (Director of Family and Community Support). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Sara Miranda to Program Manager VI (Director, Family & Community Support) be approved.

In a letter dated January 14, 2000, Blake M. Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of the reappointments to the Active and Consulting Medical Staffs of Western Massachusetts Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the active and consulting medical staffs of Western Massachusetts Hospital be approved:

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LIC. NO.:**
Theodore King, M.D.	Pulmonary	5694
Arthur Sher, M.D.	Dermatology	35317

In a letter dated January 12, 2000, Katherine Domoto, M.D., Associate Executive Director for Medicine, Tewksbury Hospital, Tewksbury, recommended approval of appointments and reappointments to the medical staff of Tewksbury Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the medical staff of Tewksbury Hospital be approved for a period of two years beginning January 1, 2000 to January 1, 2002:

APPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LIC. NO.:**
Elizabeth Donlon, M.D.	Psychiatry	156017
Daniel Breslin, M.D.	Psychiatry	60138
Siobhan O'Neill, M.D.	Psychiatry	158509
Bernard Stotsky, M.D.	Psychiatry	27904
James Thompson, M.D.	Psychiatry	73230

REAPPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LIC. NO.:**
Venkata Satyam, M.D.	Internal Medicine	53327

STAFF PRESENTATION:

"ADVANCE DATA DEATHS 1998" – BY JENNIFER NORTON, ABBIE AVERBACH AND BRUCE COHEN, BUREAU OF HEALTH STATISTICS, RESEARCH AND EPIDEMIOLOGY:

Ms. Jennifer Norton, Division of Research and Epidemiology, said in part, "…In 1998, 55,204 Massachusetts residents died. The largest number of deaths occurred among persons 85 years and older. Racial disparity persists in death rates. The good news is that AIDS and HIV mortality continued to decline. There was a 12 percent decline from 1997. Injury-related deaths account for 74 percent of all deaths among persons ages 15 to 24 years old. There are high rates among the elderly, especially among persons the age of 85 plus years. The five leading causes of death have remained the same from 1995, with heart disease and cancer the number one and number two causes followed by stroke, pneumonia and influenza and chronic obstructive pulmonary disease. Combined, heart disease and cancer accounted for 54 percent of all deaths in 1998…The gap between heart disease and cancer is narrowing. In 1990, heart disease accounted for about 33 percent of all deaths, while cancer accounted for about 25 percent of all deaths…All cause mortality is down 8 percent from 1990, cancer is down 5 percent, heart disease is down 20 percent, stroke is down 14 percent, and motor vehicle and homicide rates are down 30 percent and 54 percent, respectively. "

Ms. Norton continued, "…Massachusetts does much better than the rest of the nation in most causes of death. For all causes of death, the Massachusetts age-adjusted death rates are lower than the United States, as well as for cases such as heart disease, stroke, unintentional injuries, and AIDS. Only for cancer, pneumonia and influenza are the rates higher in the Commonwealth compared to the nation…The leading causes of death vary by age. For persons ages 1 through 14, the leading cause of death was unintentional injuries, excluding motor vehicle related injuries. For persons ages 15 to 24, motor vehicles related injuries were the leading cause of death, accounting for 30 percent of all deaths. For persons ages 24 to 44, cancer was a leading cause of death, with breast

cancer as the leading cause of cancer deaths. For persons ages 45 through 64, cancer is also the leading cause of death. And the same for persons ages 65 through 74. For people ages 75 through 84, heart disease was the leading cause of death, as well as for people 85 plus. For the first time, Advance Data Deaths is providing detailed information about deaths among persons ages 65 years and older. In 1997, persons aged 65 years and older accounted for 13 percent of the total Massachusetts population. By reporting detail in these categories we observed some interesting trends. The number of deaths varied greatly by gender, particularly among people aged 85 plus. The number of deaths is much greater among females….Mortality rates vary not only by age, but by race and ethnicity. Racial disparities continue to persist. The age-adjusted mortality rates are highest among blacks, and lowest among Asians. The causes of death vary by race as well. Heart disease is a leading cause of death among whites, but cancer is a leading cause of death among Asians, blacks, and Hispanics. Lung cancer is the leading cause of cancer death for both genders, although rates are higher for males than females. Colorectal cancer is the second leading cause of cancer death among males, and the third leading cause of cancer death among females. Prostate cancer is the third leading cause of cancer death among males."

"Injury-related death rates are 2.9 times higher for males than for females, with the age-adjusted death rate 47.0 per 100,000 for males, compared to 16.1 per 100,000 for females. While 13 percent of all injury-related deaths occur among persons ages 15 to 24 years old, injury-related deaths account for 74 percent of all deaths in this age group. The five leading causes of death in this age group are injury-related, with motor vehicle related injuries as the leading cause of death in this age group, followed by suicide, homicide, unintentional injuries, excluding motor vehicle related injuries, and other injuries undetermined. While accounting for a small percentage of the total deaths among the oldest, injury-related death rates are highest for this age group, compared to other age groups. The age-specific death rate involved other injuries such as drowning, falls, and fires is 241.6 per 100,000 for persons ages 85 plus…The good news is that AIDS and HIV-related mortality continues to decline…Historically, rates have been highest among persons of non-Hispanic black race. In 1998, the number of Hispanic AIDs deaths was higher than the number of black non-Hispanic black AIDs deaths, although the age-adjusted rates are similar. This is something to track and to follow. Comparison analyses with the AIDs surveillance database suggest there is more complete reporting of AIDS death on death certificates among Hispanics. "

Ms. Norton concluded, "As public health workers, we strive to improve the health of our communities. While we cannot prevent death, there are roots of morbidity and mortality that are preventable…Diet and physical inactivity were the leading cause of preventable death in Massachusetts in 1998, followed by tobacco. Diet and physical inactivity account for 10,000 deaths, tobacco accounts for 9,000 deaths. Many diseases are multifactorial, and this approach does not completely account for that…Less than 5 percent of health care dollars nationally are invested in prevention, but many of the causes of death are preventable. Therefore, the goal continues to be the need to focus on prevention in public health."

INFORMATIONAL BRIEFING ON PROPOSED AMENDMENT TO THE SUITABILITY REVIEW PROCESS HSA V PILOT PROJECT (105 CMR 153.022(B)):

Dr. Paul Dreyer, Director, Division of Health Care Quality, said, "The Division proposes the attached amendment to the Long Term Care Facility Licensure Procedure and Suitability Requirements at 105 CMR 153.022(B). The amendment will extend the duration of the suitability review HAS V project through March 31, 2005. Under the current regulations, the project expires on March 31, 2000. This project was established as part of the suitability review process for prospective owners/licensees of long term care facilities. Since 1990, 60 public notices of intent to acquire a long term care facility in HSA V have been published. As a result of these notices, 23 hearings have been requested by residents of HSA V and conducted by the Department. The Department will conduct a comment period on the proposed amendment and return to the Council with a final recommendation.

NO VOTE

REGULATIONS:

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 430.000: MINIMUM SANITATION AND SAFETY STANDARDS FOR RECREATIONAL CAMPS FOR CHILDREN, STATE SANITARY CODE, CHAPTER IV:

Mr. Howard Wensley, Director, Division of Community Sanitation, said in part, "…We are asking for approval for final promulgation of certain amendments to the recreational camp code. The first hearing we held in March of 1999 relative to a single definition of a residential camp for children. The existing regulations stated that a residential camp is a camp that basically gave care to children for four consecutive twenty-four hour periods…The Department proposed to change the amendment to four consecutive overnights. We held hearings. One major issue we discussed and looked at is the definition of a recreational camp for children, the general definition. We were bombarded by the church groups, because technically under the existing definition of recreational camp for children, the vacation Bible schools fell into that particular definition. Church groups were very concerned that it was putting an undue burden on them by requiring background checks and that the buildings meet certain specifications. It basically was putting them out of business, and children were not being afforded the ability to come in off the street for a week or two to have Bible lessons. We also received word from some camps that they were having some problems with their health care consultant. Health care consultant was defined basically as a physician, M.D., a nurse practitioner, or a P.A. who was required to sign off, or basically approve medications being brought to camp from home on a camper by camper basis. We were receiving concerns that the consultants would not do this because they felt that it was perceived that they were second guessing the prescribing provider, and did not want to get involved in that, and also had some concerns relative to potential liability…We received some

concerns from the camp that they were not sure what an immunization certificate was. We require that all campers coming to camp provide an immunization certificate proving that they are up to date on immunizations. Another major issue that was mentioned, primarily by the Boards of Health, and to some degree by some camps, was the requirement that before a camp could be licensed by the Board of Health, it had to be inspected and found to meet all the requirements. The camping industry is unique. They are generally here today, gone tomorrow. A lot of them are one week programs. They are ready to open, ready to be inspected maybe a couple of days before camp. And it was creating a very real problem for Boards of Health and camps, in all cases, to do the inspections prior to licensing. Based upon these comments, and some other ones, the Department of Public Health proposed some amendments, and held a public hearing in December.

In response to some of these concerns, the Department is proposing to amend the definition of a recreational camp for children. Primarily a recreational camp for children is not a classroom-based instructional or recreational instructional program where there are no specialized or high risk activities associated with it. We are talking there riflery, aquatics programs, archery, horseback riding - those type of programs. This will eliminate from the definition of a recreational camp such programs as the vacation Bible schools, where basically they are sitting in a classroom in the church. It will eliminate music programs that are primarily just in a classroom or an auditorium. It will also eliminate what previously had been licensed as recreational camps: several computer-type programs. It is our opinion that this will or should satisfy the concerns that we received from the church groups in that they will no longer be regulated as recreational camps for children…Relative to the immunization certificate, we worked with our immunization staff in the Department and came up with a determination that an immunization certificate is any report signed by an MD, or his or her designee, or a report of the Mass. Immunization Information System. The information on that also has to be dated as to basically month and year, and the specific vaccine that was given…Relative to licensing prior to inspection, we understand the problems with trying to get into all these camps, and the lack of resources on the parts of the Boards of Health to be able to do it early on. What we proposed in these regulations is to exempt the need for a pre-licensing inspection of day camps, where they are under the same ownership, directorship, previous inspections have been good, and the Board of Health has reason to believe there is no evidence of danger to the children. We chose not to do that for residential camps…We chose to make that a differential in the licensing."

Mr. Wensley continued, "…The last major issue that we had to deal with was the issue of medication administration in the camps. The compromise that we have made is rather than having these physicians, or the health care consultant, sign off on meds given to individual campers, that they merely have to sign off on a list of medications that are being given at the camp, indicating that they are comfortable with the administration at the camp and that they have provided training to the person providing the administration and indicating that the person doing the administration at the camp would by under their professional oversight. ''

Ms. Tracy Miller, Deputy General Counsel, said, "…I just wanted to make it clear that we spent a lot of time over the last couple of years looking at the definition of recreational camps for children, and trying to clarify it, because there was a lot of confusion, not just from the vacation Bible camps, but from a lot of other groups trying to determine whether or not they fell within the definition of a recreational camp. I want to make it clear that it was not just the Bible schools' concerns and efforts, there were many other programs. We made an effort to try and lay out in the definition clear categories, so as to assist both camps and local Boards of Health in trying to make that determination. The clarification that we made with regard to the health care consultant, as to whether or not the health care consultant needed to actually second guess or sign on to the prescriptive authority of the primary physician, it was our position that they were not doing it last year. This was merely a clarification, it was not a change. But because there was some misunderstanding about how they were worded, we tried to clarify it this year."

After consideration, upon motion made and duly seconded, it was voted (unanimously): **to approve the Request for Final Promulgation of Amendments to 105 CMR 430.000: Minimum Sanitation and Safety Standards for Recreational Camps for Children, State Sanitary Code, Chapter IV**; that a copy of the amended regulations be forwarded to the Secretary of the Commonwealth; and that a copy of the amended regulations be attached to and made a part of this record as **Exhibit Number 14,669**. Public hearings were held in March 1999 and December 1999.

REQUEST FOR FINAL PROMULGATION OF AMENDMENTS TO 105 CMR 155.000, ENTITLED PATIENT AND RESIDENT ABUSE PREVENTION, REPORTING, INVESTIGATION, PENALTIES AND REGISTRY:

Dr. Paul Dreyer, Director, Division of Health Care Quality, said in part, "We are here to request final promulgation of amendments to 105 CMR 155.000, entitled Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties and Registry…The regulations implement Chapter 336 of the Acts of 1998 which extend some of the protections of the patient abuse reporting requirement statute from nursing homes to home health agencies. We brought these regulations to Council in May of 1999 when they were released for public hearing. The public hearing was held last July. Now we are bringing them to you for promulgation. The major features of the regulations are they expand the Department's investigative authority to include working for home health agencies, homemaker agencies and hospices. They expand the types of individuals who are mandatory reporters of suspected patient abuse to people who work in those settings. They require that the Department investigate cases of misappropriation of patient or resident property, in addition to patient or resident abuse in those settings. And they require us to establish or maintain a registry that includes findings of patient or resident abuse made against home health aides or homemakers who work in those nonfacility settings. That's in addition to our current responsibility for maintaining a registry of nurse aides. Finally, the regulations require that home health agencies, homemaker agencies, and hospice programs check the registry before hiring an employee to determine whether or not the individual is on the registry with a finding of abuse. If there

is such a finding, then the facility or agency is prohibited from hiring the individual during the time period of any sanction or suspension that might be in effect."

Dr. Dreyer continued, "After the public hearing, there were a number of minor technical changes that we made. The one substantive change had to do with the timing of investigations of misappropriation. Essentially the change that we have incorporated says that the home health agency has twenty–four hours to investigate an allegation of misappropriation to determine whether there has been some likely misappropriation on the part of a home health aide. If the agency determines that there is a likely misappropriation, then the agency will report it to the Department; otherwise not. This differs from nursing homes where any loss of property is the facility's responsibility, and in one's home a loss of property might or might not be associated with a nurse aide. That is why we are giving the agency the latitude to make that determination…"

After consideration, upon motion made and duly seconded, it was voted (unanimously**): <u>to approve the request for final promulgation of amendments to 105 CMR 155.000, entitled Patient and Resident Abuse Prevention, Reporting, Investigation, Penalties and Registry</u>**; that a copy of the approved regulations be attached to and made a part of this record as **Exhibit Number 14,670**. A public hearing was held on July 9, 1999.

The meeting adjourned at 10:55 a.m.

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Howard K. Koh, M.D., M.P.H.
Chairman